Medicare, Medigap, & You

A guide to making your best choices

about Medicare and Medigap policies (Medicare supplements)

Published by the Office of Washington State Insurance Commissioner Mike Kreidler

A message from the Insurance Commissioner

The retired, pre-retirement, and early retirement populations make up the largest and fastest-growing group of consumers in the state. When you add those with disabilities, more than one million residents of Washington state are eligible for Medicare.

Since Medicare, retirement, and disability raise a host of complex issues and choices, the Office of the Insurance Commissioner is committed to ensuring that consumers in Washington State are fully informed about their options.

The Office of the Insurance Commissioner publishes other health insurance guides to educate and assist consumers. A list of these and additional resources is printed on the inside back cover of this publication.

Take full advantage of the expertise our Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine volunteers can offer you. Their assistance is *free* and completely objective. No SHIBA HelpLine volunteer has any affiliation with any insurance company or product.

SHIBA HelpLine serves *all* of Washington state, including people who need to make decisions about individual insurance, government programs (Medicare, Medicaid, Basic Health, Washington State Health Insurance Pool), Medigap (supplementing Medicare benefits obtained at age 65 or through disability), employment-related benefits, managed care, long-term care, medical billings, and more.

Dial toll-free: 1-800-397-4422 for the number of the SHIBA HelpLine office nearest you. Or visit www.insurance.wa.gov or www.insurance.wa.gov/shibahelpline.htm.

with questions, comments, complaints about other insurance (auto, life , homeowners, disability, ETC.)
CALL:

INSURANCE COMMISSIONER'S TOLL-FREE CONSUMER HOT LINE
1 (800) 562-6900

Medicare Overview

Medicare alone isn't enough for most beneficiaries

When it was enacted in 1965 as part of the Social Security Act, Medicare's purpose was to increase access to health care and reduce its financial burden on older, retired or disabled Americans. Medicare was never intended to pay 100 percent of all medical bills, but instead to offset the most pressing medical expenses by providing a basic foundation of benefits.

Thus, while it provides considerable support, *Medicare does not cover all services that you might need.* Even those that are covered are not covered in full. There are deductibles, coinsurance, and—with some physicians—charges over and above what Medicare considers reasonable and necessary (the allowed charge). Medicare will not pay above that limit.

That's why you may need additional coverage —to fill gaps Medicare was never intended to fill. Most Medicare beneficiaries need some kind of plan, policy or program--"Medicare enhancements"--to fill in these gaps in Medicare's basic coverage.

There are several ways to enhance Medicare. One of them is a special private insurance policy called a Medigap policy (Medicare supplement). This guide is designed to help you understand the Medigap option—the basics of how Medicare works and how the fee-for-service (reimbursement) system works using a Medigap policy to fill Medicare's gaps.

SHIBA HelpLine publishes other guides designed to explain other Medicare enhancement options, such as managed care, employment-related benefits, and the Washington State Health Insurance Pool (WSHIP). To order these guides, use the order form on the last page of this guide, go to www.insurance.wa.gov, or call SHIBA HelpLine at (800) 397-4422.

Medicare Part A coverage

Part A provides substantial hospital care benefits, covering reasonable and necessary services and supplies to treat illness or injury. It also provides *very limited* coverage for skilled nursing care after hospitalization, rehabilitative services, and home health care, and hospice care for the terminally ill. It does *not* pay for personal (custodial) care (e.g., help with eating, dressing, walking or other Activities of Daily Living).

Under Medicare Part A, a period of hospitalization is called a benefit period. A benefit period begins the day you are admitted into a hospital. It ends when you have been out of the hospital or a nursing facility for 60 consecutive days. If you are re-admitted within that 60 days, you are still in the same benefit period and would not pay another deductible. If you are admitted to a hospital after that benefit period ends, an entirely new benefit period begins (and a new deductible is owed).

Medicare Part B coverage

Part B helps pay for medical and surgical care, diagnostic tests and procedures, some hospital outpatient services, laboratory services, durable medical equipment and a variety of medical services and supplies.

It does *not* cover prescription drugs, nor most preventive or routine services, including dental care, acupuncture, foot care, eye examinations, eyeglasses, hearing aids, physicals or other services not related to treatment of illness or injury. Two notable exceptions are routine Pap smears and mammography, which are covered.

PART A Medicare benefits are as shown below:

The deductibles and coinsurance for which you are responsible (as shown in these charts) change annually. To obtain current figures, consult the **Centers for Medicare and Medicaid Service's [CMS]**' *Medicare Handbook*, at www.medicare.gov, or a local SHIBA HelpLine volunteer at 1-800-397-4422 or www.insurance.wa.gov/shibahelpline.htm.

SERVICE	MEDICARE PAYS	YOU PAY
In-patient hospital, days 1 through 60	**After one-time DEDUCTIBLE, 100% of approved charges**	**DEDUCTIBLE**
In-patient hospital, days 61 through 90	**Approved charges over & above DAILY COINSURANCE**	**DAILY "Days 61-90" COINSURANCE**
In-patient hospital, days 91 through 150*	**Approved charges over & above DAILY COINSURANCE***	**DAILY "Days 91-150" COINSURANCE***
Skilled nursing facility, days 1 through 20 (IF YOU ENTER WITHIN 30 DAYS OF A 3-DAY HOSPITAL STAY)	**100% of approved charges** (IF YOU ENTER WITHIN 30 DAYS OF A 3-DAY HOSPITAL STAY)	**NOTHING—*IF...*** YOU ENTER WITHIN 30 DAYS OF A 3-DAY HOSPITAL STAY AND ARE RECEIVING SKILLED REHABILITATIVE CARE
Skilled nursing facility, days 21 through 100	**Approved charges after DAILY SNF COINSURANCE**	**DAILY SNF Days 21-100 COINSURANCE**

PART B Medicare benefits are as shown below:

SERVICE	MEDICARE PAYS	YOU PAY
Doctors, outpatient hospital care, durable medical equipment, and other services and supplies	**80% of approved charges after ANNUAL DEDUCTIBLE OF $100**	• **First $100 each year (ANNUAL DEDUCTIBLE)** • **20% of approved charges** • **100% of excess charges (over and above Medicare-approved amount)** • **100% for services not covered by Medicare**
Diagnostic testing, lab services	**100% of approved charges**	**Nothing**

"Fee for service"

How your health and medical services are delivered and paid for, what your out-of-pocket costs may be, and how those costs are covered depends on the type of Medicare enhancement solution you choose.

You may obtain Medicare-covered services using the fee-for-service approach (paying "as you go" for each service/provider), being reimbursed by private insurance to fill gaps. (We will briefly discuss other options later in this guide: obtaining Medicare-covered services from a managed care plan or from a former employer's plan. Consult SHIBA HelpLine's *Managed Care, Medicare and You; Managing Your Managed Care;* and *Retirement and Your Health Insurance* for additional, detailed information on these options.)

The "fee-for-service" system is a pay-per-visit arrangement. You see a licensed physician at a facility certified by Medicare when you need a treatment, service or exam. Medicare is billed each time you receive care. Depending on the service, Medicare will either cover part of the bill or none. Under fee-for-service, you are responsible for:

- Medicare deductibles and coinsurance;
- fees for services not covered by Medicare;
- amounts charged by providers that exceed Medicare's approved charge for the service.

Under the fee-for-service system, you can use insurance to pay out-of-pocket expenses not covered by Medicare when you need medical or hospital care. The goal of insurance is to cover some or all of these expenses (as well as deductibles and co-payments).

Out-of-pocket expenses

Out-of-pocket expenses occur:

- when you receive a service not covered by Medicare;
- when you receive a service only partially covered by Medicare;
- when you choose a provider whose fees exceed Medicare's approved charges.

How much of these expenses you pay out of pocket depends on the extent of your insurance coverage. In the next section of this guide, we will discuss situations in which out-of-pocket expenses can occur even when covered by Medicare, and how Medigap policies—as one type of Medicare enhancement solution—can address these.

Medigap Insurance

What are Medigap policies?

Medicare supplements (commonly called Medigap policies) are health insurance policies that provide a way to fill the coverage gaps left by Medicare, which are illustrated by the charts on the previous page. Depending on which one you buy, the policy will cover some or all of the potential charges you see in the "You Pay" columns of those charts.

Before you decide on any Medicare-enhancing solution, familiarize yourself with the detailed benefits, rules and procedures of Medicare itself.

The Centers for Medicare and Medicaid Services (CMS), which administers the Medicare program, produces these guides:

- Medicare & You
- Guide to Health Insurance For People With Medicare
- Medicare and Other Health Benefits
- Understanding Your Medicare Choices

All are free, and can be obtained by writing to the address given at the end of this guide (see "Resources" at back of guide) or at www.medicare.gov.

Are all Medigap policies the same?

In 1992, federal regulations set uniform standards for Medigap (Medicare supplement) policies. Now there are 10 standardized Medigap plans (Plan A through Plan J). Prior to 1992, there was no standardization among these plans.

So, while Plans A through J differ *from one another,* each Plan conforms to federal standards for that particular Plan. In other words, all Plan Bs meet specific standards; all Plan Gs conform to a set of standards, and so on.

For example, no matter which company you buy Plan E from, it will cover all of the same things that any other company's Plan E does. No company offers a "better" or different Plan E. Therefore, when selling these plans, insurance companies compete based on premiums, service, company reliability, and issues such as waiting periods for pre-existing conditions or guaranteed issue after open enrollment.

Plan A is the most basic policy and offers "core benefits." These include the daily coinsurance you would normally pay for days 61-90 in hospital, the daily coinsurance you would pay during lifetime reserve days 91-150, and the 20 percent that you would pay for services if you relied solely on Medicare.

The core benefits also cover 100% of hospital costs for an additional 365 days, once in a lifetime, *after* your Medicare benefits are exhausted.

Each of the nine plans named B - J includes all of the core benefits offered in Plan A, as described above, *plus* varying levels of additional coverage. Each plan addresses a different set of Medicare "gaps," adding benefits such as coverage for medical emergencies in a foreign country,

prescription drugs, or preventive medical care. You can choose the best policy for you based on your health, lifestyle and other factors.

NOTE: Policies purchased prior to 1992 were not changed by the regulations that became effective that year, and thus do not conform to the current uniform standards.

Will a Medigap policy cover everything that Medicare doesn't?

As you will see in the chart on the next page, no single policy covers everything—but not everyone needs every single benefit. Each plan offers a different group of benefits to cover a different grouping of "gaps."

The idea is to carefully consider *your* particular needs and choose the supplement policy that fills the gaps most likely to affect *you*.

A detailed explanation of each plan is featured in the free publication *Guide to Health Insurance for People with Medicare* (see "Resources" at back of this Guide) or at www.medicare.gov.

Special Medigaps

Two new Medigap policies may be offered with the same benefits as Plans F and J, but with an annual deductible. (The deductible for these plans is $1,530, but this could change in the future.) Premiums could potentially be lower than for the standard F and J Plans.

Medigap policies E & J are available to Washington state resident Medicare enrollees through the Washington State Health Care Authority (HCA). The plans are issued only when certain criteria are met, such as new residency, retirement, first-time Medicare enrollment, or other special periods which may be designated in the future. There are no pre-existing condition waiting periods for these plans.

What is "open enrollment?"

By law, people age 65 or above have the right to enroll in any Medigap health insurance plan within six months after their Medicare Part B coverage begins. *No one* age 65 or older may be denied coverage because of a pre-existing medical condition if they apply for a Medigap policy during this six months.

When does coverage begin?

This varies by policy, but Washington state law limits Medigap policy waiting periods to a 90-day maximum in *all policies purchased after January 1, 1996.*

In a waiting period, medical conditions for which you have been treated previously can be excluded from your coverage until the waiting period has elapsed. Check with your insurance agent, or consult a SHIBA HelpLine volunteer, for assistance in determining what is and is not covered during your policy's waiting period (if any).

10 STANDARDIZED MEDICARE SUPPLEMENT PLANS

BASIC (CORE) BENEFITS	PLAN A	PLAN B	PLAN C	PLAN D	PLAN E	PLAN F	PLAN G	PLAN H	PLAN I	PLAN J
Part A Hospital (Days 90); Lifetime Reserve Days (Days 91-150); 3 Lifetime Hosp. Days at 100%; Parts A & B Blood Deductible; Part B 20% Coinsuran	X	X	X	X	X	X	X	X	X	X
ADDITIONAL BENEFITS	A	B	C	D	E	F	G	H	I	J
Skilled Nursing Coinsur.			X	X	X	X	X	X	X	X
Part A Deductible		X	X	X	X	X	X	X	X	X
Part B Deductible			X			X				X
Part B Excess Charges						100%	80%		100%	100%
Foreign Travel Emergency			X	X	X	X	X	X	X	X
At-Home Recovery				X			X		X	X
Prescription Drugs								X	X	X
Preventive Medical Care					X					X

(NOTE: Two "high-deductible" Medigap policies may be offered with the same benefits as Plans F and J.)

What is "Accepting Assignment?"

For many services and procedures, there is a limit to the fee amount Medicare will approve. This is called the "approved charge" (or allowable, eligible or accepted charge).

In the "Original Medicare" fee-for-service system, when doctors or other health care providers accept assignment, they agree to accept this approved amount—the maximum charge Medicare will allow for that service—as payment in full. In other words, they won't bill *you* more for a service than Medicare will approve. These physicians are referred to as participating providers.

Some physicians accept assignment as a general practice; others may do so on a case-by-case basis. Ask before you visit a new physician.

If a provider does accept assignment, this minimizes—but does not eliminate—your share of the bill. Medicare pays 80 percent of the approved charge. You are still responsible for the coinsurance—20 percent of the approved charge.

If you have a Medigap policy, it will cover your portion of the approved charge. (All Plans A through J cover the 20 percent coinsurance—it's a core benefit.)

What if a provider does not "accept assignment?"

Doctor does not accept assignment, charges:	$115.
Medicare-approved charge for Service XYZ:	$100.
You pay:	
• 20% of approved charge (20% of $100):	$ 20.
• Charges in excess of the approved charge for this service ($115 minus $100):	$ 15.
TOTAL YOU PAY:	$ 35.
Medicare pays 80% of the approved portion (80% of $100):	$ 80.

A provider who does not accept assignment can charge more than Medicare approves. In this case, you are responsible not only for the usual 20 percent of the approved charge for the service, but also for *100%* of the *excess* charges—the portion of the fee that exceeds the approved amount.

However, there is a limit to *how much* more than the approved amount a *physician* may charge. This is called a limiting charge. Non-participating *physicians* may not charge more than 115% of the Medicare-approved amount for a covered service. (Not all providers and services are subject to this limiting charge, although other limits may apply in some cases.)

Also, several Medigap policies cover excess charges. If you have one of these, it will pay all or part of the amount over and above what Medicare approves.

More details about these issues can be found in the free *Medicare Handbook* and *Guide to Health Insurance for People with Medicare*, both at www.medicare.gov (see "Resources" at back of guide). You can also obtain a free listing of participating doctors and suppliers in your area by calling your local Medicare carrier (see "Resources" at back of guide).

What if I can't afford a Medigap policy?

Since not all Medicare beneficiaries can afford private Medigap insurance, the Federal government has made funding available through the states for several programs to assist eligible beneficiaries. These programs, called Medicare Savings Programs, are the Qualified Medicare Beneficiary (QMB), the Specified Low Income Medicare Beneficiary (SLMB) and Expanded Specified Low Income Medicare Beneficiary (ESLMB, also known as QI and Q2).

QMB pays all Medicare premiums, deductibles, and coinsurance, and can take the place of a Medigap policy except for prescription coverage. SLMB pays Medicare Part B premiums; ESLMB pays a portion of Part B premiums. To qualify, your income cannot exceed a specific monthly amount, and your assets must also be below a certain amount. A home and car are usually exempt.

Qualifying figures change annually. For current income/asset limits and to determine if you qualify, contact your local Department of Social and Health Services (DSHS), your local DSHS Community Service Office (CSO), or the National Elder Care Locator service at (800) 677-1116 or www.aoa.gov/elderpage/locator.html.

If you find that your income and assets are below the qualifying levels for QMB, you may qualify for Medicaid, which pays nearly all health care costs, including prescription drug costs. Contact your local Area Agency on Aging, or go to a local DSHS Community Service Office to apply.

Do I need more than one Medigap policy?

The 10 standard plans each offer different groupings of benefits to address a wide range of individual needs. One policy is sufficient in most cases.

It is illegal for an agent or company to sell you a plan that duplicates coverage you already have (unless you agree to cancel the coverage you already have).

Can my insurer cancel my Medigap policy?

Medigap policies purchased by individuals are guaranteed renewable. As long as you pay your premiums on time, your policy cannot be terminated without your permission.

However, group policies may be cancelled and converted to similar—though not the same—coverage. Group policies are those that are issued to you through a legitimate group (such as an employer organization) and require employment or membership in the organization. Certificates of insurance are issued to participating members. To determine if you have a group policy, read your policy or contact a SHIBA HelpLine volunteer.

What if I change my mind about a policy?

Washington state law gives you a 30-day "free-look" period after you receive a Medigap policy. If you change your mind for any reason, return it *within that time* for a full refund.

Are there other ways to extend benefits?

Yes. You can sometimes keep your employer's plan, and its benefits may supplement Medicare. You can enroll in a Medicare+Choice option such as a Medicare-contracting managed care plan, in which you pay a small monthly premium (or no premium, in some cases) for a package of services through a managed care provider. Private-fee-for-service (PFFS) plans, Tri-Care for Life (for military retirees and their spouses) and the Qualified Medicare Beneficiary (QMB) program *(see page 9)* are also options for some.

Thoroughly inform yourself about the pros and cons of these options before you enroll. A SHIBA HelpLine volunteer can provide information or a side-by-side comparison of coverage.

What if I'm covered by an employer's plan?

Some Medicare beneficiaries are covered by an employer's plan, either because they continue to work after age 65 or because the employer plan covers retirees. In some cases this coverage is superior to a Medigap policy or managed care plan. A SHIBA HelpLine volunteer can help you compare your employer plan to other options, so you can decide which best meets your need.

To avoid possible penalties, it is important to understand the many complex enrollment deadlines and rules associated with Medicare and retirement. For complete information about your choices as a retiree or pre-retiree, order SHIBA HelpLine's free *Retirement and Your Health Insurance* (order form at back of guide, or see www.insurance.wa.gov or www.insurance.wa.gov/shibahelpline.htm)

Policy Definitions

Following are standardized definitions of terms or benefits specifically found in Medigap policies.

Excess charges: The difference between the amount Medicare approves and the maximum any physician may legally charge (limiting charge).

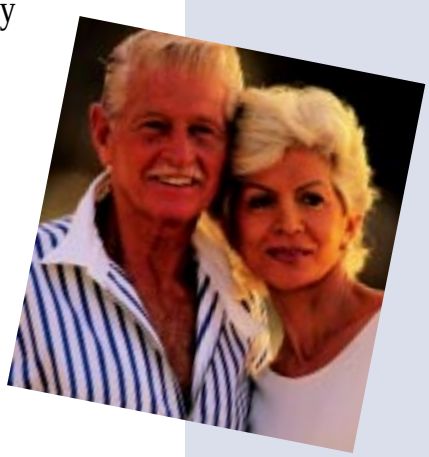
Foreign travel emergency: This benefit covers medically necessary *emergency* care received in a foreign country at *80 percent of the billed charge* for Medicare-eligible emergency hospital, doctor and medical care costs. This care must be of the kind that would have been covered in the U.S. by Medicare and must begin *during the first 60 days* of each trip outside the U.S. This is subject to $250 deductible and a lifetime maximum of $50,000.

At-home recovery: This benefit extends the Medicare benefit to provide coverage for short-term, at-home assistance with activities of daily living for those recovering from illness, injury or surgery. It pays up to $40 a day or $1,600 annually, *but only after at least one visit is paid by Medicare. To qualify, you must first be eligible for Medicare home care.*

Basic drug benefit: Coverage for *50 percent* of outpatient prescription drug charges after a *$250 calendar year deductible,* to a *maximum of $1,250 annual benefits,* to the extent not covered by Medicare.

Extended drug benefit: Coverage for *50 percent* of outpatient prescription drug charges after a *$250 calendar year deductible,* to a *maximum of $3,000 annual benefits,* to the extent not covered by Medicare.

Preventive care benefit: This coverage pays *up to $120 annually* for a routine or preventive physical exam or care that is not already covered by Medicare.



Glossary

Acute: A condition that begins suddenly and doesn't last very long. This is the opposite of chronic. A broken hip is an acute condition.

Accept assignment: When doctors and other health care providers accept assignment, they agree to bill no more than the approved charge for a service. In other words, they won't charge more than Medicare will approve.

Approved charge: Also called the allowable, eligible, or accepted charge, this is the pre-set maximum that Medicare will approve for a particular service or procedure (of which Medicare will reimburse 80%).

Benefit period: A designated period of time during and after a hospitalization for which Medicare Part A will pay benefits.

Chronic: A medical condition that is recurring or lasts a long time—e.g., arthritis.

Coinsurance: The balance of a covered health expense that an individual is required to pay after insurance has covered the rest.

Deductible: A pre-determined amount of money, designated in the insurance policy, that an individual making a claim must pay before the policy begins to pay.

Guaranteed renewable: A policy that cannot be canceled without the policyholder's consent (except for nonpayment of premiums).

Limiting charge: The maximum a physician who does not accept assignment may legally charge for a Medicare-covered service.

Managed care: A health coverage plan in which you pay a monthly premium (or no premium) for a complete package of services through a network of providers you must use.

Medicaid: A financial assistance program administered by state government with federal assistance that helps cover medical care for impoverished individuals and families.

Enrollment period: If you are 65 or over, you have the right to enroll in any Medigap insurance plan within six months of when your Medicare Part B coverage begins, and cannot be denied based on any pre-existing condition (though a waiting period might be imposed).

Pre-existing condition: A medical condition diagnosed or treated up to three months prior to the purchase of an insurance policy. Medigap policies may impose up to a 90-day waiting period before coverage for that condition begins.

Skilled care: When conditions require the care of skilled medical staff (such as registered nurses or physical therapists) it is called skilled care. In most cases, it must be ordered by a physician before insurance will cover it.

Usual and customary charge: The fee most commonly charged by providers for a particular service, procedure or treatment, for that specialty, in that geographic area.

Helpful Hints

on buying health insurance

- **Read** your policy and be sure you understand what it does and does not cover. If there is anything you do not understand, do not sign anything or pay for anything before someone (a knowledgeable friend or family member, SHIBA HelpLine volunteer, or attorney) is able to answer your questions.

- **Ask** for a plain-language outline of coverage. This is an easy-to-understand summary of a policy's benefits, exclusions and limitations. Insurers are required to provide them for every policy. You should take advantage of it if the policy's "legalese" has you confused.

- **Don't be pressured** into "buying now." You will save a great deal more in the long run if you take the time to understand your rights and options, and choose the best policy for you, than if you rush to take advantage of a "special offer" the agent claims is about to expire.

- **Ask** for a copy of the policy and review it with a knowledgeable friend or family member, SHIBA HelpLine volunteer, or attorney before you buy.

- **Always** pay for your policy by check or money order—not with cash. Or arrange for monthly automatic withdrawal from your checking account.

- **Make** the check payable to the insurance company, not the agent or agency.

- **Get a receipt** any time you give a check to an agent or broker.

- **Double-check** to make sure all the information on your application form is correct. If an insurance company has issued you a policy based on incorrect information, it may consider this grounds for cancelling your policy or not paying certain claims.

- **Choose** an agent with whom you feel comfortable, who is experienced in the type of insurance you are purchasing, who is willing to answer your questions or obtain information for you, and who is knowledgeable and helpful. You are not required to deal with any particular agent; if you are unhappy with one agent, find another.

IF YOU NEED MORE HELP...

SHIBA HELPLINE is an impartial, confidential resource to help you evaluate, choose and use your health insurance.

A statewide network of highly trained volunteers stands ready to educate you on health insurance issues, so you can make informed decisions. Our counselors have up-to-date information on most health insurance concerns. They can answer questions and assist with insurance planning.

Their services are FREE. And they have no affiliation with any insurance company or product.

SHIBA HELPLINE was the first health insurance peer counseling program of its kind in the nation, and is now a model for the rest of the United States.

SHIBA HELPLINE has an office in nearly every Washington State county. Call to get the number of the SHIBA HelpLine sponsor nearest you.

1-800-39-SHIBA
(1-800-397-4422)

RESOURCES

HOTLINES, ORGANIZATIONS

- For consumer brochures about health insurance, and referral to nearest local SHIBA office: SHIBA HelpLine / (800) 397-4422
www.insurance.wa.gov/shibahelpline.htm

- With all other insurance questions/comments/suggestions *(auto, life, homeowner, etc.)* :
Insurance Commissioner's Consumer Hotline / (800) 562-6900
www.insurance.wa.gov

- Centers for Medicare and Medicaid Services (CMS)
Consumer Services (206) 615-2354
Medicare Hotline (800) 638-6833
Medicare Managed Care (206) 615-2351
www.medicare.gov

- Social Security Administration (800) 772-1213
www.ssa.gov

- National Elder Care Locator Service (800) 677-1116

- Health Care Authority (360) 923-2600
www.wa.gov/hca

- Public Employees Benefit Board (PEBB) (800) 399-7271

PUBLICATIONS

Centers for Medicare and Medicaid Services (CMS)
www.medicare.gov 1-800-MEDICARE

- *Medicare & You; Guide to Health Insurance for People with Medicare ; Your Medicare Benefits; Medicare and Other Health Benefits: Your Guide to Who Pays First ; Medicare Hospice Benefits; Medicare and Your Mental Health Benefits; Medicare and Home Health Care; Medicare Coverage of Skilled Nursing Facility Care; Your Guide to the Outpatient Prospective Payment System; Women With Medicare; Medicare Savings Programs (see website for more)*

National Association of Insurance Commissioners (NAIC)

- *A Shopper's Guide To Long-Term Care Insurance*
Publications Dept., 120 West 12th Street, Suite 1100
Kansas City, MO 64105

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- ☐ The Consumer's Guide to Financing Long-Term Care
- ☐ Info on options for consumers with disabilities
- ☐ Info on prescription drug coverage
- ☐ Info on individual insurance market/under 65

☐ Please send information on becoming a SHIBA HelpLine volunteer.

☐ I'm interested in having a speaker for my group. Please call me. _____

Name of group _____ Location of group _____

Size of group (audience) _____

Phone number _____ E-mail address _____

See SHIBA HelpLine's website at www.insurance.wa.gov/shibahelpline.htm for other helpful consumer brochures, handouts, charts, guides, and fact sheets that can be downloaded or ordered from the site.

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SHIBA (Statewide Health Insurance Benefits Advisors) HelpLine
810 Third Avenue Suite 640
Seattle, WA 98104-1615
1-800-397-4422

Need help with an insurance problem or question? The Insurance Commissioner's Consumer Advocacy division has experts in all lines of insurance (auto, homeowner, life, disability and health) who can assist you. Call our toll-free hot line at 1-800-562-6900.

In addition, if you need help with health insurance issues, Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine is a free service of the Insurance Commissioner's office. SHIBA HelpLine provides specialized health insurance education, assistance, and advocacy, including individualized counseling regarding your rights and options. Call 1-800-397-4422 to be referred locally for assistance.

Medicare, Medigap, & You

is part of the consumer guide series

published by The Office of the Insurance Commissioner

SEE ALSO:

- Retirement and Your Health Insurance
- Managed Care, Medicare & You
- Consumer's Guide to FInancing Long-Term Care
- Health Insurance Options for People with DIsabilities
- Health Insurance Options in the Individual Market
- Navigating Managed Care
- Cutting Prescription Drug Costs
- It's Your Choice: Health Insurance, Health Providers & State Law (Access to Alternative Health Care)
- Women: You have the right to go directly to your women's health care provider
- Insurance Decoded: Consumer Guide to Insurance Terms

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